

 **This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.anthem.com](http://www.anthem.com) or by calling 1-800-582-6941.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	In Plan and Out of Plan providers <b>\$2,000</b> Individual/ <b>\$4,000</b> Family combined, per Plan Year. Does not apply to in-network Preventive care services and PreventiveRx Expanded drugs.	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	<b>\$4,000</b> Individual/ <b>\$8,000</b> Family for In Plan providers. <b>\$9,000</b> Individual/ <b>\$18,000</b> Family for Out of Plan providers.	The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, balance-billed charges, routine vision, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Is there an overall annual limit on what the plan pays?	No.	This plan will pay for covered services only up to this limit during each coverage period, even if your own need is greater. You're responsible for all expenses above this limit. The chart starting on page 2 describes <i>specific</i> coverage limits, such as limits on the number of office visits.
Does this plan use a <u>network of providers</u> ?	Yes. See <a href="http://www.anthem.com">www.anthem.com</a> or call 1-800-582-6941 for a list of In Network providers.	If you use an in-network doctor or other health care <u>provider</u> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .

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# Fauquier County & Schools: HealthKeepers Lumenos HDHP with HSA

Coverage Period: 07/01/2016 - 6/30/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual/Family | Plan Type: HSA

Important Questions	Answers	Why this Matters:
Do I need a referral to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about <u>excluded services</u> .

- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charge more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charge \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use In Plan **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a In Plan Provider	Your Cost If You Use a Out of Plan Provider	Limitations & Exceptions
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	20% Coinsurance	30% Coinsurance	—————none—————
	Specialist visit	20% Coinsurance	30% Coinsurance	—————none—————
	Other practitioner office visit	20% Coinsurance	30% Coinsurance	Spinal manipulations limited to 30 visit limit.
	Preventive care/screening/immunization	No Charge	30% Coinsurance	—————none—————
If you have a test	Diagnostic test (x-ray, blood work)	20% Coinsurance	30% Coinsurance	—————none—————
	Diagnostic Imaging (CT/PET scans, MRIs)	20% Coinsurance	30% Coinsurance	—————none—————

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# Fauquier County & Schools: HealthKeepers Lumenos HDHP with HSA

Coverage Period: 07/01/2016 - 6/30/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual/Family | Plan Type: HSA

Common Medical Event	Services You May Need	Your Cost If You Use a In Plan Provider	Your Cost If You Use a Out of Plan Provider	Limitations & Exceptions
<p>If you need drugs to treat your illness or condition.</p> <p>More information about <u>prescription drug coverage</u> is available at <a href="http://www.express-scripts.com">www.express-scripts.com</a> or <a href="http://www.anthem.com">www.anthem.com</a></p>	Generic drugs	20% Coinsurance	<p>If you choose a non-network pharmacy, you will pay the full cost of your drug, and will need to submit an ESI drug claim form to be reimbursed up to plan allowance minus applicable deductible and coinsurance.</p>	<p><b>Deductible and coinsurance do not apply to preventive care drugs and drugs listed on the PreventiveRx Expanded plan drug list.</b></p> <p>Up to a 30-day supply for Retail Pharmacy. Up to a 90-day supply for Mail.</p> <p>Mail Order is not covered for Out of Plan providers.</p>
	Preferred brand drugs	20% Coinsurance		
	Non-preferred brand drugs	20% Coinsurance		
	Specialty drugs	20% Coinsurance		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	30% Coinsurance	—————none—————
	Physician/surgeon fees	20% Coinsurance	30% Coinsurance	—————none—————
If you need immediate medical attention	Emergency room services	20% Coinsurance	30% Coinsurance	Out of network reimbursed at in-network level for true emergencies only.
	Emergency medical transportation	20% Coinsurance	30% Coinsurance	—————none—————
	Urgent care	20% Coinsurance	30% Coinsurance	—————none—————
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance	30% Coinsurance	—————none—————
	Physician/surgeon fee	20% Coinsurance	30% Coinsurance	—————none—————

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# Fauquier County & Schools: HealthKeepers Lumenos HDHP with HSA

Coverage Period: 07/01/2016 - 6/30/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual/Family | Plan Type: HSA

Common Medical Event	Services You May Need	Your Cost If You Use a In Plan Provider	Your Cost If You Use a Out of Plan Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% Coinsurance	30% Coinsurance	_____none_____
	Mental/Behavioral health inpatient services	20% Coinsurance	30% Coinsurance	_____none_____
	Substance abuse disorder outpatient services	20% Coinsurance	30% Coinsurance	_____none_____
	Substance abuse disorder inpatient services	20% Coinsurance	30% Coinsurance	_____none_____
If you are pregnant	Prenatal and postnatal care	20% Coinsurance	30% Coinsurance	_____none_____
	Delivery and all inpatient services	20% Coinsurance	30% Coinsurance	_____none_____
If you need help recovering or have other special health needs	Home health care	20% Coinsurance	30% Coinsurance	Limited to 100 visits
	Rehabilitation services	20% Coinsurance	30% Coinsurance	Occupational and physical therapies limited to 30 combined visits and speech therapy limited to 30 visits.
	Habilitation services	20% Coinsurance	30% Coinsurance	All rehabilitation and habilitation visits count toward your rehabilitation visit limit.
	Skilled nursing care	20% Coinsurance	30% Coinsurance	Limited to 100 days per admission.
	Durable medical equipment	20% Coinsurance	30% Coinsurance	_____none_____
	Hospice service	20% Coinsurance	30% Coinsurance	_____none_____
If your child needs dental or eye care	Eye exam	\$15 Copay/Visit	\$30 allowance	One routine eye exam per plan year.
	Glasses	Not Covered	Not Covered	Discounts are available.
	Dental check-up	Not Covered	Not Covered	_____none_____

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## Excluded Services & Other Covered Services:

### Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs

### Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care
- Private Duty Nursing  
(16 hrs per member per plan year maximum)
- Coverage provided outside the United States.  
See [www.BCBS.com/bluecardworldwide](http://www.BCBS.com/bluecardworldwide)

## Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay - while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-582-6941. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

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## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact:

Anthem HealthKeepers, Inc.  
Attn: Corporate Appeals Department  
P.O. Box 27401  
Richmond, VA 23279

Express Scripts, Inc.: Attention: Pharmacy Appeals, Mail Route BL0390, 6625 West 78<sup>th</sup> Street, Bloomington, MN 55439.

Department of Labor's Employee Benefits Security Administration  
1-866-444-EBSA (3272)  
[www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform)

The Office of the Managed Care  
Ombudsman, Bureau of Insurance  
P.O. Box 1157, Richmond, VA 23218  
Additionally, a consumer assistance program can help you file your appeal. Contact:  
Virginia State Corporation Commission  
Life & Health Division, Bureau of Insurance  
P.O. Box 1157  
Richmond, VA 23218  
(877) 310-6560  
<http://www.scc.virginia.gov/boi>  
[bureauofinsurance@scc.virginia.gov](mailto:bureauofinsurance@scc.virginia.gov)

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” This plan does meet provide minimum essential coverage.

## Does this Coverage Provide Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

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## Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-333-5735

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-333-5735

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-855-333-5735

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-855-333-5735

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*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*

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## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



**This is  
not a cost  
estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby (normal delivery)

■ **Amount owed to providers: \$7,540**

■ **Plan pays \$4,472**

■ **Patient pays \$3,068**

#### Sample care costs:

Hospital charge (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charge (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions*	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

#### Patient pays:

Deductibles	\$2,000
Copays	\$0
Coinsurance	\$1,068
Limits or exclusions	\$0
<b>Total*</b>	<b>\$3,068</b>

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)

■ **Amount owed to providers: \$5,400**

■ **Plan pays \$3,300**

■ **Patient pays \$2,100**

#### Sample care costs:

Prescriptions*	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

#### Patient pays:

Deductibles	\$2,000
Copays	\$0
Coinsurance	\$100
Limits or exclusions	\$0
<b>Total*</b>	<b>\$2,100</b>

\*Assumes prescriptions are PreventiveRx Expanded plan drugs and covered at 100%.

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## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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